MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01260 Z 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years, 20 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 8 years, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1426 East Lombard Street (If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3.(a) FULL NAME: ADAMS - FLORENCE

3.(b) Social Security Number: -------

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: John Adams, 1426 E. Lombard St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years: 62 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ------

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial, cremation, or removal. Which? burial Date thereof 3/6-46 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md
18. Funeral director: Dubt - Hospital
Address: Crownsville Md

19. (Date rec'd by registrar) Mar 6 1946 E. J. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 1946 at 8:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 31 1938 to Feb. 21 1946 and that I last saw her alive on February 21 1946

	DURATION
Immediate cause of death: Lung Tuberculosis	Known to us since 2/18/46
Due to: ------	
Due to: ------	
Other conditions: Senile Psychosis (Include pregnancy within 3 months of death)	Known to us since 1/31/38

Major findings of operations: ------ Date of op.: ------
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ------

23. SIGNATURE: Herbert J. Thompson M. D. or other
Address: Crownsville, Maryland Date signed: 2/21/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-2

CERTIFICATE OF DEATH

01261

Reg. Diat. No. 24322

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: County: Anne Arundel - City or town: Odenton Rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural, Odenton (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Nancy Bevins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: Mot Lemon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1872

8. AGE: Years: 74 | Months: .. | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Union County NC (Town, county, and state)

10. Usual occupation: Home work

11. Industry or business

FATHER — 12. Name: Thomas Rucian, 13. Birthplace: N.C.

MOTHER — 14. Maiden name: Liza, 15. Birthplace:

16. Informant: Jamie B Rawlings Address: Odenton Md RFD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 28 46 (month) (day) (year)

Cemetery or crematory: Fork Church

Location: Anne Arundel Co.

18. Funeral director: Martin Hodemo Sons Address: Bowie Md

19. Feb 28 19 46 (Date rec'd by registrar) Mrs. J. W. Yingling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 19 46 at 3.40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 19 46 to Feb 25 19 46 and that I last saw h-er alive on Feb 22 - 19 46

Immediate cause of death: (a) Pneumonia Hipostatic. DURATION: 3 days

Due to: (b) Carcinoma of Uterus Bedridden. DURATION: 1 year

Due to: (c)

Other conditions: Nephritis, Hypertension (Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: O. H. Mac Nemar M.D. M. D. or other

Address: Millersville Md Date signed: 2/25/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

01262

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A. Co.
City or town Hanover Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 yrs.
Hospital, Institution, or street address where death occurred:
Race Rd., near Dorsey
How long in hospital or Institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Howard A.A.
City or town Hanover, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Race Rd. near Dorsey
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME Philip Blob.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widower.

B.(b) Name of husband or wife Katherine Schrank

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Exact date unknown.

8. AGE	Years	Months	Days	If less than one day
about	68	?	?	? hrs. ..... min.

9. Birthplace Bavaria, Germany (Town, county, and state)

10. Usual occupation Farmer. (Retired)

11. Industry or business .....

FATHER
12. Name Martin Blob
13. Birthplace Germany

MOTHER
14. Maiden name Unknown
15. Birthplace .....

16. Informant Mrs. John Blob
Address Hanover, Md., R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/2/46 (month) (day) (year)
Cemetery or crematory St. Lawrences
Location Jessup, Md.

18. Funeral director Wm. J. Dickshen & Sons
Address North & Penna. Ave., Balto. Md.

19. 3-1 19 46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27 19 46 at 10 15 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 19 46 to Feb. 27 19 46
and that I last saw him alive on Feb. 26 19 46

Immediate cause of death	DURATION
Cerebral Haemorrhage & Hemiplegia.	10 days.
Due to Hypertension & Arterio-sclerosis.	5 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Frank Shipley, M.D. M. D. or other
Address Savage, Md. Date signed 2/27/46.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Dist. No. 01263 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs, 10 mos, 1 day

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 8 yrs, 10 mos, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -------

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 1 Kelly Court (If rural, give LOCATION)

2.(a) If veteran, name war: -------

3.(a) FULL NAME: BUTLER - ANNIE

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE:	Years	Months	Days	If less than one day
	77	unknown		--- hrs. --- min.

9. Birthplace: Harford County, Maryland (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER — 12. Name: Jim B. Thompson

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Hannah (unknown)

MOTHER — 15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 3/6.46 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt -

Address: Crownsville Md

19. Mar 6 1946 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 20 1946 at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 1937, to Feb. 20 1946 and that I last saw her alive on February 20 1946

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 4/19/37
Due to: ------	
Due to: ------	
Other conditions: Senile Psychosis	Known to us since 4/19/37

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.: -----

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 2/20/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

01264

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Riva Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Riva Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Maynard Carr

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Harriett Dorsey Carr
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feby 15th 1856
8. AGE: Years 89 Months 11 Days 26 If less than one day hrs. min.
9. Birthplace: A. A. Co. Md. (Town, county, and state)
10. Usual occupation: Judge of Orphans Court
11. Industry or business: Ct. A. A. Co. Md.
FATHER 12. Name: Philip D. Carr
13. Birthplace: A. A. Co. Md.
MOTHER 14. Maiden name: Harriet Dorsey
15. Birthplace: A. A. Co. Md.
16. Informant: Maynard Carr Jr.
Address: R.F.D. Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 12th 1946 (month) (day) (year)
Cemetery or crematory: St Stephens Cemetery
Location: Millersville A.A.Co. Md.
18. Funeral director: John M. Taylor & Son
Address: Annapolis Md.
19. Feb. 12 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 9, 1946, at 2.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 3 1945 to Feb 9 1946 and that I last saw h. alive on Feb 8 1946

Immediate cause of death	DURATION
(a) Pulmonary edema	2 hrs.
Due to (b) Chr. Myocarditis	yrs.
Due to (c) Senility	
Other conditions: Arteriosclerosis Diabetes Arthritis	yrs.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. J. Klawans, MD M. D. or other
Address 31 South Gate Av Date signed 2/10/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

BC 01265

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 18 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 years, 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1600 Latrobe Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: COLES - EMMA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE: Years: 75 | Months: unknown | Days: | If less than one day: ---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Cook
11. Industry or business: ----

FATHER
12. Name: Henry Higgins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Daniel
15. Birthplace: Virginia

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 23, 1946 (month) (day) (year)
Cemetery or crematory: Mt. ~~Auburn~~ Calvary
Location: Baltimore, Maryland

18. Funeral director: Mrs. Frances T. Hemsley
Address: 578 W. Biddle Street, Baltimore, Md.

19. Feb 20 1946 (Date rec'd by registrar) E7 Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19 1946, at 1:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1943, to Feb. 19 1946 and that I last saw her alive on February 19 1946

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 2/1/43
Due to: ---	
Due to: ---	
Other conditions: Senile Psychosis	Known to us since 2/1/43

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ----
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ----
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 2/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01266

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 5 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no home
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: COX - EMMA JANE

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1859 ?

8. AGE: Years: 87 ? Months: unknown Days: If less than one day: ---- hrs. ---- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 9/46 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem.
Location: A. A. County

18. Funeral director: Mrs Robert Elliott & daughter
Address: 1129 N. Caroline St.

19. 2/8 (Date rec'd by registrar) 19 46 A.W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 19 46 at 3:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 19 45 to Feb. 5 19 46
and that I last saw her alive on February 5 19 46

	DURATION
Immediate cause of death: Chronic Myocarditis	Known to us since 10/30/45
Due to: ------	
Due to: ------	
Other conditions: Senile Psychosis (Include pregnancy within 3 months of death)	Known to us since 10/30/45

Major findings of operations: --------
Date of op.: -----
Autopsy results: -------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: --------
Where did injury occur? (City or town) (County) (State) ----------
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ---------- Injured at work? ---------

23. SIGNATURE: Hal J. Pinderock M. D. or other
Address: Crownsville, Maryland Date signed: 2/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 57 — 01267

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Dorsey
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Race Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: John George Debrick

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Blanche
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 16 1861

8. AGE: Years	Months	Days	If less than one day
84	7	0	____ hrs. ____ min.

9. Birthplace: Baltimore, Md,
(Town, county, and state)
10. Usual occupation: Fuel Business-- Self
11. Industry or business:

FATHER
12. Name: John Debrick
13. Birthplace: Germany

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Laura M. Debrick
Address: Race Rd. Dorsey Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 20th 1946 (month) (day) (year)
Cemetery or crematory: Oaklawn Cemetery
Location: Baltimore, Co. Md.

18. Funeral director: William J. Tickner & Sons
Address: North & Pennsylvania Aves.

19. Feb. 19 1946 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16th 1946 at 11:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 29 1945, to Feb 16 1946 and that I last saw h alive on Feb 16 1946

	DURATION
Immediate cause of death: Myocardial Insufficiency	2 hrs
Due to: Arteriosclerosis	5 yrs
Due to: Senility	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.: none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 409 Main St Elkridge Date signed: 2/19/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

01268 8

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 56-d

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Markey Neck Rd
City or town Solley Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Solley
City or town Solley
(If outside city or town limits, write RURAL and give nearest town)
Street No. None
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary M. Dewling
3.(b) Social Security Number —

4. Sex Female
5. Color or race W
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age 7 years
7. Birth date of deceased (mo., day, yr.) June 1, 1938
8. AGE: Years 7 Months Days If less than one day ...hrs. ...min.
9. Birthplace Baltimore
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Henry Dewling
13. Birthplace Balto.

MOTHER
14. Maiden name Margaret White
15. Birthplace Balto.

16. Informant Henry Dewling
Address Markey Neck Rd
17. Burial Date thereof Feb 13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Holy Cross Cem.
Location Arundel County
18. Funeral director Bernard Harle
Address 1000 S. Paca St.
19. 2/12 1946 [signature] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1946 at 7 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1946 to Feb 7 1946
and that I last saw her alive on Feb 5 1946
Immediate cause of death Brain tumor — DURATION 1 yr
Adamantinomal of hypophyseal duct. Benign tumor.
Due to Duration: one year by history.
Congenital. Probably present since birth.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations Tumor of brain
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur?
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [illegible] Date signed 2/11/46

STATE OF MARYLAND—CERTIFICATE OF DEATH

02074

1. PLACE OF DEATH

County A.A.C. MD Registration Dist. No. 23

Village or City Near Friendship Church No. Severn Md St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of rasidanca in city or town whera daath occurrad ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

2. FULL NAME ANNIE WESLEY DOWNS If U. S. Veteran, specify WAR ___

(a) Residence: No. HANOVER MD. Fort Meade St. Ward

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
female	white	Widow ~~married~~

5a. If married, widowed, or divorcad HUSBAND of (or) WIFE of GEORGE W. DOWNS

6. DATE OF BIRTH (month, day, and yaar) April 21 1873

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
72	10	7	

OCCUPATION

8. Trade, profassion, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc. Retired

9. Industry or business in which work was dona, as SILK MILL, SAW MILL, BANK, etc.

10. Data deceasad last workad at this occupation (month and year)

11. Total tima (yaars) spent in this occupation

12. BIRTHPLACE (city or town) A.A.CO. MD. (State or country)

FATHER

13. NAME WM. R. WESLEY

14. BIRTHPLACE (city or town) A.A.CO. (Stata or country)

MOTHER

15. MAIDEN NAME MARY E. CROMWELL

16. BIRTHPLACE (city or town) A.A.CO. (Stata or country)

17. INFORMANT GEORGE W. DOWNS JR

(Address) HANOVER MD.

18. BURIAL, CREMATION, OR REMOVAL

Place FRIENDSHIP Date March 2, 1946

19. UNDERTAKER John O. Mitchell Hanover

(Addrass) 1900 Patuxent Place

20. FILED 3/2/46, 19 [illegible] Woodruff Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH February 28 (Month) (Day), 1946 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan. 1942 to Feb 28 1946

I last saw h[illegible] alive on Feb. 28, 1946; daath is said to hava occurrad on tha data statad above, at 3 P. m.

The PRINCIPAL CAUSE OF DEATH and ralated causas of importance wara as follows:

	Date of onset
Chronic Cardio. Vascular Renal	1943
Other Contributory Causes of importanca: Chronic Interstitial Nephritis.	1941

Name of operation None Date of

What test confirmad diagnosis? — Was there an autopsy? No

23. If daath was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Whara did injury occur? (Specify city or town, county and State)

Specify whather injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceasad? No

If so, spacify —

(Signed) James S. Buckingham M. D.

(Address) Glen Burnie. Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01269

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address (if not in hospital):

28 East St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 East

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ida R. Ford

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Benjamin J Ford

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Jan 1 — 1866

8. AGE:

Years	Months	Days	If less than one day
80	1	23	..... hrs. ..... min.

9. Birthplace: maryland (town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: John Rodgers

FATHER — 13. Birthplace: maryland

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Edward J Ford

Address: 105 Charles St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 27 46 (month) (day) (year)

Cemetery or crematory: Locust Bluff

Location: Annapolis Md

18. Funeral director: B E Hopkins

Address: Annapolis Md

19. Feb. 25 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 23 1946, at 5 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Feb 23 1946 and that I last saw him alive on Feb 22 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	48 hrs
Due to: Arterio Sclerosis	Several yrs.
Due to:	
Other conditions: Hemiplegia	1 yr +

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Oliver Purnell M. D. or other

Address: Annapolis Md Date signed: 2/23/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01270

CERTIFICATE OF DEATH

Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 904 Paca
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I.

3. (a) FULL NAME: Joseph Funki

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1896

8. AGE: Years	Months	Days	If less than one day
50			hrs. min.

9. Birthplace: Lithuania (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Farming
FATHER 12. Name: —
13. Birthplace: —
MOTHER 14. Maiden name: —
15. Birthplace: —
18. Informant: Max Blob
Address: Jessups. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5-46 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem.
Location: Anne Arundel County
18. Funeral director: Bernard Hasle
Address: 1000 S. Paca St.
19. V-4 (Date rec'd by registrar) 19 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 1 19 46, at not known M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination 19
and that I last saw h alive on Feby. 2 19 46
Immediate cause of death: Acute Dilatation of Heart — DURATION: sudden
Due to: Cardiac asthma — 2 years
Due to: Chronic myocarditis — 2 years
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: John M. Caffry, Deputy Medical Examiner
M. D. or other
Address: Annapolis Md. Date signed 2/2/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-A)

CERTIFICATE OF DEATH

01271

Reg. Dist. No. 2

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Spa Road Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A-A-
City or town: S Pa. Road, Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 608 Central Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Moses Galloway

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	married

6.(b) Name of husband or wife: Mary Galloway
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1872.

8. AGE:

Years	Months	Days	If less than one day
74	1		hrs. min.

9. Birthplace: South River, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Henry C. Galloway
13. Birthplace: md
MOTHER 14. Maiden name: Matilda ?
15. Birthplace: Md.
16. Informant: Mary Galloway
Address: 608 Central Ave. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1946 (month) (day) (year)
Cemetery or crematory: Brewers Hill
Location: Annapolis, Md.
18. Funeral director: J.B. Johnson
Address: Annapolis, Md.
19. Feb. 13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10 1946 at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 9, 1946, to Feb 10, 1946 and that I last saw h[illegible] alive on Feb 10, 1946

Immediate cause of death	DURATION
Acute Myocarditis	
Due to: Pulmonary Edema	2 days
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L.P. Richardson M. D. or other
Address: Annapolis, Md. Date signed: 2/13/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01272

CERTIFICATE OF DEATH

★ Reg. Dist. No. 23

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Mollie Gardner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~F~~ M	W.	married

6.(b) Name of husband or wife: Geo. F. Gardner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7 - 1877

8. AGE: Years	Months	Days	If less than one day
68	10	13	hrs. min.

9. Birthplace: Jessup Md.

(Town, county, and state)

10. Usual occupation: Housekeeping duties

11. Industry or business:

FATHER — 12. Name: Albert Boyer

13. Birthplace: Severn Md.

MOTHER — 14. Maiden name: Annie Shipley

15. Birthplace: Severn Md.

16. Informant: George F. Gardner

Address: Harmons Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 22-1946 (month) (day) (year)

Cemetery or crematory: Friendship Cem.

Location: Anne Arundel County

18. Funeral director: Wm J. Tickner & Son.

Address: North & Penhaven. Balto Md.

19. Feb. 20 1946 (Date rec'd by registrar) M. Wallace Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19-46 19 at 1.09 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10-45 to Feb 19-46

and that I last saw h[illegible] alive on Feb 18th 1946

Immediate cause of death	DURATION
Lobar Pneumonia	1 day
Due to	
Due to Essential Hypertension	
Other conditions Cardio Vascular Disease	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Odenton Md Date signed: Feb 20-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0127328

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs, 3 mos, 29 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 15 yrs, 3 mos, 29 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: -----

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: 445 Sharp Street (If rural, give LOCATION)

2.(a) If veteran, name war: -----

3.(a) FULL NAME: GRIER - MATTIE

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married ?

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: unk years

7. Birth date of deceased (mo., day, yr.): 1880

8. AGE: Years	Months	Days	If less than one day
66	unknown		--- hrs. --- min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER — 12. Name: Frank Grier

13. Birthplace: Virginia

MOTHER — 14. Maiden name: Maria ?

15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 2/27/46 (month) (day) (year)

Cemetery or ~~crematory~~: Hospital

Location: Crownsville

18. Funeral director: Asst Hospital

Address: Crownsville Md

19. 2/27/46 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 19 46 at 5:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 14 19 30, to Feb. 13 19 46 and that I last saw her alive on February 13 19 46

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to: Hypertension	
Due to: -------	
Other conditions: Alcoholism - Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 10/14/30

Major findings of operations: ----------

Date of op.: ------

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of: ------

Where did injury occur? (City or town) (County) (State) ---------

Injured at home, farm, industry, public place (where?): ----------

Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Harl J. Smallwood M. D. or other

Address: Crownsville, Maryland Date signed: 2/13/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30)

CERTIFICATE OF DEATH

01274

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Pasadena P. O. Md.

City or town Lake Shore
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 1918

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Pasadena P. O.

City or town Lake Shore
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war None

3. (a) FULL NAME George Leonard Hammerbacher

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Divorced

B.(b) Name of husband or wife Maude Hammerbacher B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 7, 1867

8. AGE: Years	Months	Days	If less than one day
79	0	15	hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation XXXXXXXX Musician

11. Industry or business Self

FATHER 12. Name Leonard Hammerbacher

13. Birthplace Germany

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Lillian Hammerbacher

Address Lake Shore Pasadena P. O. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2.25.46 (month) (day) (year)

Cemetery or crematory Loudon Park Cemetery

Location Baltimore Md.

18. Funeral director WM. J. TICKNER & SONS INC

Address North & Pa Aves. Baltimore, Md.

19. 2-22 1946 L. A. Blair
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1946, at 9 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940, to Feb. 22 1946 and that I last saw h im alive on Feb. 21 1946

Immediate cause of death	DURATION
Cerebral hæmorrhage	4 days
Due to Arteriosclerosis	chronic
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. A. Blair, M. D.
M. D. or other

Address Pasadena Md. Date signed 2-22-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

bw 012752 1

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 8 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1145 North Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: HANDY - CLARA

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ------
6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years	Months	Days	If less than one day
68	unknown		----- hrs. ----- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Teacher
11. Industry or business: -----

FATHER
12. Name: Thomas Jones
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elise Jackson
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 9, 1946 (month) (day) (year)
Cemetery or crematory: New Cathedral
Location: Baltimore City
18. Funeral director: George G. Kelson
Address: 1303 Presstman Street, Baltimore, Md.

19. 2/8 1946 (Date rec'd by registrar) A W Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1946, at 9:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 1945, to Feb. 5 1946 and that I last saw her alive on February 5 1946

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 3/27/45
Due to: ------	
Due to: ------	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	Known to us since 3/27/45

Major findings of operations: ------ Date of op. -----
Autopsy results: ------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of -----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ------
Means of injury: ------ Injured at work? -----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 2/5/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01276

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Freetown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Freetown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: CLARENCE GRAFTON HOWARD

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lydia Howard

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): August 30, 1895

8. AGE:

Years	Months	Days	If less than one day
50	5	6	hrs. min.

9. Birthplace: Freetown, A. A. Co., Md.
(Town, county, and state)

10. Usual occupation: chauffeur

11. Industry or business: long distance hauling

FATHER
12. Name: Charles Howard
13. Birthplace: A. A. Co., Md.

MOTHER
14. Maiden name: Eliza J. Brown
15. Birthplace: A. A. Co., Md.

16. Informant: Rilla Sedgwick
Address: P. O. Glen Burnie, Md.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 2-10-46
(month) (day) (year)

Cemetery or crematory: Marley Neck Cemetery

Location: A. A. Co., Md.

18. Funeral director: Isiah Brown

Address: Montgomery st., Baltimore

19. 2-5-46 (Date rec'd by registrar)

L. A. Okeefe
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 19 46, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-12-45 19 to 2-5-46 19 and that I last saw h... im alive on 2-4-46 19

Immediate cause of death	DURATION
Mediastinal tumor (exact nature unknown). There was no opera-	8 mos.
Due tion and no autopsy. No further infor-	
mation. C. G. O.	
Due to	
Other conditions: Pneumonia, bronchial.	6 ds.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. A. Okeefe, M.D.
M. D. or other

Address: Laurel, Md. Date signed 2-5-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

01277

Reg. Dist. No. 2312

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Nov. 1 - 1945

Hospital, institution, or street address where death occurred:

Crain Hyway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State County

City or town Same

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Blanche Elizabeth Hughes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife James A Hughes

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 24 - 1872

8. AGE: Years 73 | Months 5 | Days 3 | If less than one day hrs. min.

9. Birthplace Baltimore Md.
(Town, county, and state)

10. Usual occupation Home Wife -

11. Industry or business

FATHER 12. Name Nathan G. W. Vermillion

13. Birthplace Malboro Md.

MOTHER 14. Maiden name Cathenn Benson

15. Birthplace Malboro Md.

16. Informant Melvin Bach

Address Millersville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-2-46 (month) (day) (year)

Cemetery or crematory ST JOHNS Beltsville Cemetary

Location Beltsville Md

18. Funeral director W. W. Chambers Co

Address 1400 Chapin St N. W.

19. 2/28 1946 Amanda Downey

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 27 1946, at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20. 1946, to Feb. 27 1946

and that I last saw h alive on Feb. 27 1946

Immediate cause of death	DURATION
Cancer of Cecum	3 to 4 yrs
Due to	
Due to	
Other conditions Intestinal Obstruction due to the Cancer.	1 week

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. none.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M. D. or other

Address Linthicum Date signed 12-27-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

01278

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town 515 Sixth St.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Eastport Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edna S. Isaacs.

3.(b) Social Security Number

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Lawrence Isaacs
6.(c) If wife, give age ... years
7. Birth date of deceased (mo., day, yr.) June 26th 1898
8. AGE: Years 47 Months 7 Days 19 If less than one day ... hrs. ... min.
9. Birthplace York Pa. (Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Unknown
13. Birthplace
MOTHER 14. Maiden name Unknown
15. Birthplace
16. Informant Lawrence A. Isaacs
Address 515 Sixth St. Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17 1946 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor & Son
Address Annapolis Md.
19. Feb 15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 14 1946, at 2:30 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Feb 14 1946 and that I last saw h.. alive on Feb 12 1946

	DURATION
Immediate cause of death: Generalized Carcinomatosis	4 Yrs
Due to: Carcinoma of Breast Removed	1941
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE George C Boyd M. D. or other
Address Annapolis Md. Date signed 2-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

01279 P

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 26

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 months, 12 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 11 months, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ———
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 632 Baker Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ———

3.(a) FULL NAME: JORDAN - FRANCES

3.(b) Social Security Number: ———

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

B.(b) Name of husband or wife: ———
6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): February 25, 1929

8. AGE:	Years	Months	Days	If less than one day
	16	11	10	——— hrs. ——— min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ———

FATHER
12. Name: Samuel Jordan
13. Birthplace: Baltimore, Maryland

MOTHER
14. Maiden name: Mary Newman
15. Birthplace: Baltimore, Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 9, 1946 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City

18. Funeral director: George G. Kelson
Address: 1303 Presstman Street, Baltimore, Md.

19. 2-9 (Date rec'd by registrar) 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1946, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 23 1945, to Feb. 5 1946
and that I last saw her alive on February 5 1946

Immediate cause of death	DURATION
Chronic Endocarditis	Known to us since 2/23/45
Due to: Rheumatic Fever	
Due to: ———	
Other conditions: Moron	Known to us since 2/23/45

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———
Autopsy results: ———
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ——— Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? ———

23. SIGNATURE: Lloyd V. Brinkerhoff M. D. or other
Address: Crownsville, Maryland Date signed 2/5/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01280

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a. a.

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Gloucester

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: maryland County: a. a.

City or town: annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 185 Gloucester

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: agnes Lindeborn

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f	w	widow

6.(b) Name of husband or wife: Charles Lindeborn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): aug 24 — 1862

8. AGE:	Years	Months	Days	If less than one day
	83	6	1	..... hrs. ..... min.

9. Birthplace: annapolis, md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Robert Redmond

13. Birthplace: Ireland

MOTHER

14. Maiden name: Elizabeth Dempsey

15. Birthplace: Scotland

16. Informant: mrs Geo K Weber

Address: 185 Gloucester St Annapolis. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 28/46 (month) (day) (year)

Cemetery or crematory: St Annes

Location: annapolis md

18. Funeral director: B. C. Heppner

Address: annapolis. md

19. Feb. 28 1946 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 25 1946, at 8 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1945, to Feb 25 1946 and that I last saw h... alive on Feb 24 1946

Immediate cause of death	DURATION
Myocarditis + Myocardial Insufficiency	3 years
Due to	
Due to	
Other conditions: Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: George C. Bail M. D. or other

Address: Annapolis md Date signed: 2-27-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

★ 012827 Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Ft. Geo. G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, Institution, or street address where death occurred:
Regional Hosp., Ft. Geo. G. Meade, Maryland

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Friendship
(If outside city or town limits, write RURAL and give nearest town)

Street No.: –
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JOSEPH E. LOVELACE

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): 15 March 1927

8. AGE: Years	Months	Days	If less than one day
18	11	0	____ hrs. ____ min.

9. Birthplace: – (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Medical Records

Address: Fort George G. Meade, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2/15/46 (month) (day) (year)

Cemetery or crematory: Wm. H. Hutchins & Son

Location: Owings, Md.

18. Funeral director: Howard N. Blight Jr.

Address: 4914 Belair Road, Balto-6-Md

19. 15 February 1946 (Date rec'd by registrar) Frank J. Tollison (Registrar)
FRANK J. TOLLISON, Capt., M.C.

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 FEBRUARY, 1946, at 0500 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3 Feb. 1946 to 14 Feb. 1946 and that I last saw him alive on 14 Feb. 1946

Immediate cause of death	DURATION
Nephritis, acute, glomerular, severe.	4 Mos.
Due to:	
Due to:	
Other conditions: Uremia	

(Include pregnancy within 3 months of death)

Major findings of operations: (None performed) Date of op.:

Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Maurice Goldberg 1st Lt MC (M. D. or other)

Address: Regional Hospital Fort Meade Date signed: 17 Feb 46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

01282

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town South River Height
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town South River Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Isabel Hess Lusk

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Walter S. Lusk
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 10th 1868

8. AGE: Years	Months	Days	If less than one day
77	5	9	..... hrs. ..... min.

9. Birthplace Iowa (Town, county, and state)
10. Usual occupation none
11. Industry or business

FATHER
12. Name Zachariah Hess
13. Birthplace New York State

MOTHER
14. Maiden name Harriett Dodge
15. Birthplace New York State

16. Informant Walter S. Lusk
Address South River Height R.F.D. Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 22 1946 (month) (day) (year)
Cemetery or crematory Taylorsville Methodist Cem.
Location Taylorsville Md

18. Funeral director John M. Taylor & Son
Address Annapolis Md

19. Feb. 22 1946 (Date rec'd by registrar) J. Bronwich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 1946 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/17 1944 to 2/20 1946 and that I last saw h...er alive on 2/20 1946

	DURATION
Immediate cause of death cerebral hemorrhage	3 days
Due to hypertensive cardio-vascular disease	15 yrs (?)
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did Injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. Bronwich M.D. M. D. or other
Address Annapolis Md Date signed 2/22/1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

EVIDENCE for change of age is shown on

FILM No. 100 FEB 12 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

01283

Reg. Dist. No. 25

1. PLACE OF DEATH:

County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ringwood Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME ~~Louis Franklin~~ ~~Frank L.~~ ~~Roy~~ Marguerite

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife None

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 10 1871

8. AGE: Years	Months	Days	If less than one day
74 75	10	25	..... hrs. ..... min.

9. Birthplace A. A. Co. Md.

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Franklin Kelly Marguerite

13. Birthplace A. A. Co. Md.

MOTHER 14. Maiden name Hannah Anna Stallings

15. Birthplace A. A. Co. Md.

16. Informant Mrs. Florence (Johnson)

Address 640 Maude Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8 1946 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Geo. Ritchie Highway

18. Funeral director Smitton & Schilling

Address 3914 S. Hanover St (25)

19. February 6 1946 Ida M. Whitman

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 5 1946, at 3:30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 6 1946, to Feb. 5 1946

and that I last saw h.. alive on Feb. 5 1946

Immediate cause of death	DURATION
Coronic - Vascular Disease	10 days
Due to	
Due to	
Other conditions Grippe & Pleurisy	1 wk

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bell Jr. M. D. or other

Address Linthicum Date signed 2-5-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01284

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Glenside, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Theodore Thomas Milan, Jr.

3.(b) Social Security Number: 225-16-5585

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 12, 1919

8. AGE:

Years	Months	Days	If less than one day
26	10	8	hrs. min.

9. Birthplace: Bakersville, North Carolina
(Town, county, and state)
10. Usual occupation: Blue Printer
11. Industry or business: Southern Railway

FATHER
12. Name: Theodore T. Milan, Sr.
13. Birthplace: Spartanburg, S. C.

MOTHER
14. Maiden name: Bessie Elliott
15. Birthplace: Rutherfordton, N. C.

16. Informant: T. T. Milan, Sr., Father
Address

17. Washington, D.C. Date thereof: Feb. 4, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory
Location

18. Funeral director: Jos. F. Birch's Sons
Address: 3034 M St., N. W.

19. Feb. 4, 1946 J. B. Dent
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1946, at 8:50 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2, 1946 to Feb 4, 1946 and that I last saw h[illegible] alive on Feb 4, 1946

Immediate cause of death	DURATION
(a) Acute Failure	1 Day
Viral Pneumonia	2 Days
Due to (b) (Collateral)	
Due to (c) Diabetis Mellitus	6 years
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: [signature] M.D.
M. D. or other
Address: 2015-17th St. N.W. Date signed: 2/4/46
Wash. D.C.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

0128

Reg. Dist. No. .....

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Greenland Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Maryland County: Anne Arundel
City or town: Curtis Bay P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Greenland Beach
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Herman Daniel Morgan

3.(b) Social Security Number 191-07-3297

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Geraldine I.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 20, 1901

8. AGE: Years	Months	Days	If less than one day
44	7	4	..... hrs. ..... min.

9. Birthplace: Pennsylvania (Town, county, and stote)
10. Usual occupation: Labor
11. Industry or business: B. & O. R. R.

FATHER
12. Name: William Morgan
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Martha Bush
15. Birthplace: Germany

16. Informant: Geraldine Irene Morgan
Address: Greenland Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 28, 1946 (month) (day) (year)
Cemetery or crematory: Johnstown, Pennsylvania
Location

18. Funeral director: William Cook, Inc.
Address: 1217 St. Paul Street

19. 2-26 19 46 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 25 19 46 at 3:30 A. M.

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination
Last saw deceased alive on Feby 25 19 46

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to Pernicious Anemia	18 months
Due to Hypotension Arterial	18 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed 2/25/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01285

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Annapolis Md. since 1896
Hospital, Institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution? 2½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 49 Paca St. Annapolis Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Henry Mowbray

3. (b) Social Security Number: 214-18-1079

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife: xxxxxxxxxxxxxxx
6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): 1895 May 5.

8. AGE: Years	Months	Days	If less than one day
50			hrs. ___ min.

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None
FATHER 12. Name: John Mowbray
FATHER 13. Birthplace: Annapolis Md.
MOTHER 14. Maiden name: Lizzie Darkins
MOTHER 15. Birthplace: —
16. Informant: Louis Mowbray
Address: 21 Obrine Court Annapolis Md.
17. burial (Burial, cremation, or removal. Which?) Date thereof 2/8/46 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: Annapolis, Md.
18. Funeral director: Mrs Chas. E. Hicks
Address: 45 Northwest St. Annapolis Md.
19. Feb. 7 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1946, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ___ 19__ to Feb 4 1946
and that I last saw h. alive on Feb 4 1946

Immediate cause of death	DURATION
Coronary thrombosis C.V.D. due to	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
None Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: [illegible] Date signed 2/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

01287

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D. #1
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: PAYNE - JEREMIAH

3.(b) Social Security Number: unknown ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Mary Payne, R.F.D. #1
Chestertown, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1871

8. AGE:

Years	Months	Days	If less than one day
75	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ------

FATHER
12. Name: Jeremiah Payne
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hesta ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 17/46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Christ Rock, Md.
18. Funeral director: Lewis H Baynum
Address: Cambridge Md

19. Feb. 13 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1946 at 8:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25 1945, to Feb. 13 1946
and that I last saw him alive on February 13 1946

	DURATION
Immediate cause of death: General Paresis	Known to us since 1/25/46
Due to: -------	
Due to: -------	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op.: -------
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---------- Date of: -------
Where did injury occur? ---------
(City or town) (County) (State)
Injured at home, farm, Industry, public place (where?): ---------
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Hugh H Brooks M. D. or other
Address: Crownsville, Maryland Date signed: 2/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (76)

CERTIFICATE OF DEATH

01288

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: North Linthicum
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? worked daily
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ferndale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Garland Park
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Paul O. Pumphrey

3.(b) Social Security Number: 218-18-1177.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Lillian Pumphrey
6.(c) If alive, give age: 36 years
7. Birth date of deceased (mo., day, yr.): March 3, 1912

8. AGE:

Years	Months	Days	If less than one day
33	11	21	..... hrs. ..... min.

9. Birthplace: Ferndale, Anne Arundel County Md (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: The Arundel Corporation
12. FATHER — Name: Knallie Pumphrey
13. FATHER — Birthplace: Ferndale, Md
14. MOTHER — Maiden name: Mattie Jordan
15. MOTHER — Birthplace: Curtis Bay, Md
16. Informant: Knallie Pumphrey
Address: Ferndale, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 25 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Ritchie Highway
18. Funeral director: Mr. & Mrs. John W. Tenfel - Sons
Address: 801 W. Fayette St.
19. 2/23/ 19 46 A. W. Hedrick Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 22 19 46, at 11.4 M
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination
and that I last saw ~~alive~~ on Feby 22 19 46
Immediate cause of death: Crushing injuries of head.
Due to: Accidental
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 2/22/46
Where did injury occur? North Linthicum (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Arundel Corporation
Means of injury: Fell with Whirley Crane Injured at work? Yes

23. SIGNATURE: John M. Claffy M.D., Deputy Medical Examiner M. D. or other
Address: Annapolis, Md Date signed 2/23/46

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92d)

02071

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:

County A.A.

City or town Jessups, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? January 5, 1946.

Hospital, institution, or street address where death occurred:
Maryland House Of Correction

How long in hospital or institution? January 5, 1946.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Unknown

City or town Unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No. Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war Unknown

3. (a) FULL NAME Harry Reed

3. (b) Social Security Number Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Unknown

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age —*— years

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years	Months	Days	If less than one day
65 estimated			...hrs. ...min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business Unknown

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant ---Md House of Correction

Address --- Jessups Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-21-46 (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Jessup Md

18. Funeral director W Loeffler

Address Jessup Md

19. Feb 21 1946 (Date rec'd by registrar) Clara Kastleh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 12, 1946 at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 7, 1946 to February 12 1946 and that I last saw him alive on February 12, 1946

Immediate cause of death	DURATION
Congestive heart failure	48 hrs.
Due to Cardio-vascular disease	Unknown
Due to	
Other conditions Hypertension	Unknown
Cerebral apoplexy with Paralysis (Include pregnancy within 3 months of death)	2-7-46

Major findings of operations None

Date of op. ------

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE John A Cash M D
M. D. or other

Address Md House Of Correction Date signed 2-15-46

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (44a)

Registered No. 22

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address A.A.Co.
(c) Hospital or institution: Inmate Md. House of Correction
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 3438 Erdman Ave. (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME William F. Runge

3 (b) If veteran, name war W. W. #2

3 (c) Social Security Account No. 218-10-5853

4. Sex: Male | 5. Color or race: White | 6 (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of ~~husband or~~ wife Elva Runge

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 8th 1914

8. AGE: Years 32 | Months 0 | Days 6 | If less than one day hr. min.

9. Birthplace Balto. Md. (Town, county, and state)

10. Usual Occupation A.B. Seaman

11. Industry or business U.S. Coast Guard

FATHER
12. Name William H. Runge
13. Birthplace Md.

MOTHER
14. Maiden Name Elsie (Unknown)
15. Birthplace Md.

16 (a) Informant Mrs Elva Runge
(b) Address 24 Ashwood Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 2/18/46 (month) (day) (year)
(c) Cemetery or ~~crematory~~ Western
Location Balto. Md.

18 (a) Funeral director William Cook Inc.
(b) Address 1217 St. Paul St.

19 (a) 2/16/46 (b) A.N. Hedrick

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 14th 1946, at 10 A. M

21. I certify that I took charge of the remains described above, held an Autopsy (Autopsy, Inspection or Inquiry) thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH Coronary thrombosis left coronary artery

Due to

Other Conditions

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:
(a) Date of injury at M.
(b) Where did injury occur?
(c) Did injury occur at home, on farm, industrial place, in public place? While at work?
(d) Means of injury

23. Signature Robert Lee Graham M.D. Medical Examiner.
Date signed 2-14-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01290

Reg. Diat. No.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred:
How long in hospital or institution? Brought dead on arrival.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Arnold
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Belvidere Beach
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Rutts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Minnie Rutts
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): Sept. 19 1888

8. AGE: Years	Months	Days	If less than one day
57	4	18	hrs. min.

9. Birthplace: Baltimore City Maryland.
(Town, county, and state)
10. Usual occupation: Male attendant,
11. Industry or business: Baltimore Both Commission

FATHER
12. Name: Michael Rutts
13. Birthplace: Baltimore Maryland

MOTHER
14. Maiden name: Mollie Kerbeck
15. Birthplace: Baltimore Maryland

16. Informant: Mrs. Minnie Rutts
Address: Belvidere Beach, Arnold Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: FEB. 8, 46 (month) (day) (year)
Cemetery or crematory: IMMANUEL
Location: Crindon LANE
18. Funeral director: L. HEEMANN & SON
Address: 32 S. BROADWAY.
19. 2/8 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 6 1946, at 1.10 P. M.
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Postmortem Examination 19..
~~and that I last saw him alive on~~ 19..

Immediate cause of death	DURATION
Coronary embolism	sudden
Due to: Coronary sclerosis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Clopp Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 2/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01292

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County a a.

City or town Germantown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 months

Hospital, Institution, or street address where death occurred:

106 Bruce ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Germantown an ampolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Bruce ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Bertha Margaret ~~Estella~~ Schroeder

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Ernest C ~~Estella~~ Schroeder

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 30 - 1860

8. AGE:

Years	Months	Days	If less than one day
85	3	8	..... hrs. ..... min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name Unknown

13. Birthplace Unknown

MOTHER

14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Ernestine S. Pfingsten

Address 106 Bruce ave

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec 11 46 (month) (day) (year)

Cemetery or crematory St Mathews

Location Baltimore Md

18. Funeral director B L Hopkins

Address Annapolis Md

19. Feb 11 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7 1946, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 6 1946, to Feb. 7 1946

and that I last saw h... alive on Feb 6 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to Arteriosclerosis	unknown
Due to	
Other conditions Myocardial Dis.	unknown

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Boyle M. D. or other

Address Annapolis Md Date signed 2-9-46

P 01291

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Pasadena
(If ontside city or town limits, write RURAL and give nearest town)
Street No. Annapolis Road
(If rural, give LOCATION)
2.(a) If veteran, name war WW

3.(a) FULL NAME August Schwab

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Annie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1866

8. AGE: Years 79 | Months 2 | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)
10. Usual occupation Retired Cabinet Maker
11. Industry or business Baltimore City

FATHER
12. Name Unknown
13. Birthplace Baltimore Md

MOTHER
14. Maiden name Unknown
15. Birthplace

16. Informant Maurice O'Connor
Address Pasadena Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/23/46 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location A. A. Co. Md.

18. Funeral director William Cook Inc
Address 1217 St. Paul St.

19. 2/22/46 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 20 19 46, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945, to Feb 20 1946
and that I last saw h.. alive on Feb 18 1946

Immediate cause of death	DURATION
Chronic Cardio Vascular Renal	2 years
Due to Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE James S. Buckingham, M D
M. D., or other
Address Pasadena, Md Date signed Feb 21, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

CERTIFICATE OF DEATH

01293

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Margate
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Ferndale
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hollins Ferry Road.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Richard Maurice M. Shipley.

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married.

6.(b) Name of husband or wife: Edna Shipley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 11, ~~1945~~ 1892

8. AGE:

Years	Months	Days	If less than one day
53	11	22	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Machenist.
11. Industry or business: Riverside Shop B.&O.R.R.
FATHER 12. Name: William H. Shipley
13. Birthplace: Anne Arundel Co.
MOTHER 14. Maiden name: Grace Stansbury
15. Birthplace: Brooklyn Md.
16. Informant: Mrs. Edna A. Shipley
Address: Ferndale, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 6 1946 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie, Md
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. Feb. 4 5pm 1946 (Date rec'd by registrar) M. E. Albaugh Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 3 1946, at M
21. I CERTIFY that death occurred on the date above stated; that ~~I attended deceased from~~ Postmortem Examination ~~19..~~ ~~to~~ Feby. 3 1946

Immediate cause of death	DURATION
Acute Dilatation of Heart	sudden
Due to: Chronic Myocarditis	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Caffey Deputy Medical Examiner
Address: Annapolis, Md. M. D. ~~or other~~ Date signed: 2/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (306)

CERTIFICATE OF DEATH

01294

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 14 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 months, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Prince George's

City or town: Croom (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

2.(a) If veteran, name war: -------

3.(a) FULL NAME: SIMMS - MARY JACKSON

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: James Simms (husband) Croom, Maryland

6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1888

8. AGE: Years	Months	Days	If less than one day
58	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER

12. Name: unknown

13. Birthplace: unknown

MOTHER

14. Maiden name: Mary ?

15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 21, 1946 (month) (day) (year)

Cemetery or crematory: Union Cem.

Location: Croom, Prince George's County, Md.

18. Funeral director: J. B. Johnson

Address: Annapolis, Maryland

19. Feb. 21 1946 (Date rec'd by registrar) E. T. Joyce Lord Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 1946, at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 2 1945, to Feb. 16 1946 and that I last saw her alive on February 16 1946

Immediate cause of death: General Paresis — DURATION: Known to us since 11/2/45

Due to: -------

Due to: -------

Other conditions: ------- (Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op. ------

Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of: ------

Where did injury occur? --------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----------

Means of injury: ------ Injured at work? -------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 2/16/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 52-2

01295

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: ANNE ARUNDEL
City or town: FORT GEORGE G. MEADE, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
REGIONAL HOSPITAL, FT. GEO. G. MEADE, MD.
How long in hospital or institution? Two days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County:
City or town: Oil City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Corn Planter Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: (Soldier, U. S. Army)

3. (a) FULL NAME: Henry G. Skubis

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8 September 1927

8. AGE: Years	Months	Days	If less than one day
18	5	16	hrs. min.

9. Birthplace: —
(Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: —
13. Birthplace: —

MOTHER
14. Maiden name: —
15. Birthplace: —

16. Informant: Medical records
Address: Regional Hosp., Ft. Geo. G. Meade, Md.

17. Disposition: Removal
(Burial, cremation, or removal. Which?) Date thereof: 2/25/46 (month) (day) (year)
Cemetery or crematory: Joseph Bansel, Undertaker
Location: 1315 Grove Ave. Oil City, Pa.

18. Funeral director: Samuel W. Blight Jr.
Address: 4914 Belair Road.

19. 25 Feb. 1946 Frank J. Tollison
(Date rec'd by registrar) FRANK J. TOLLISON, Capt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 February 1946, at 0725 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 23 Feb 46 19 to 24 Feb 1946
and that I last saw him alive on 24 Feb 1946

Immediate cause of death	DURATION
Rheumatic fever, acute, with pancarditis	2-3 wks
Congestive heart failure	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None performed
Date of op.:
Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Warren T. Vaughan Jr. M.D. or other
Address: ASF Reg. Hosp. Ft. Geo. G. Meade Md. Date signed: 26-Feb-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age of deceased is shown on

01296

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

FILM No. 100 FEB 26 1946

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Lakeshore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution? --------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Anne Arundel
City or town Lakeshore, P. O. Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war --------

3.(a) FULL NAME SAMUEL BOWERS SLAUGHTER

3.(b) Social Security Number 212-12-1672A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Bertha Slaughter
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): December 13, 1868

8. AGE: Years	Months	Days	If less than one day
77 78	8	1	....hrs. ....min.

9. Birthplace: Talbott Co., Md. (Town, county, and state)
10. Usual occupation: Plumber
11. Industry or business

FATHER
12. Name: Wm. Harrison Slaughter
13. Birthplace: Talbott Co., Md.

MOTHER
14. Maiden name: Melvina Bowers
15. Birthplace: Dover, Del.

16. Informant: (Mrs.) Bertha Slaughter
Address: P. O. Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-18-46 (month) (day) (year)
Cemetery or crematory: Easton, Md.
Location

18. Funeral director: Leo Cook
Address: Patterson Park ave., Balto.

19. 2-15-46 (Date rec'd by registrar) L. A. Blair Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 14 1946 at 11.40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1946 to Feb. 14 1946 and that I last saw h... im alive on Feb. 4-46 19....

Immediate cause of death	DURATION
Carcinoma of neck and face	25 yrs
Primary in face. On left cheek. Cancer	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Leo A. Blair M.D. M. D. or other
Address Pasadena, Md. Date signed 2-15-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-2)

CERTIFICATE OF DEATH

01297

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Regional Hospital, Ft. Geo. G. Meade, Md.
How long in hospital or institution? One day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Balto.
City or town: Baltimore - 21 Essex
(If outside city or town limits, write RURAL and give nearest town)
Street No. 619 Maryland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WILLIAM F. WEIDERMANN

3.(b) Social Security Number: V

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: Doris C. Weidermann
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 9 January, 1919

8. AGE: Years	Months	Days	If less than one day
27	1	6	hrs. min.

9. Birthplace: (Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name:
13. Birthplace:
MOTHER 14. Maiden name:
15. Birthplace:
16. Informant: Medical Records
Address: Regional Hospital, Ft.Geo.G.Meade,Md.
17. REMOVAL (Burial, cremation, or removal. Which?) Date thereof: Feb. 15, 1946 (month) (day) (year)
Cemetery or crematory:
Location:
18. Funeral director: John G. Connelly
Address: 418 Eastern Ave. Balto.21,Md.
19. 15 February 1946 (Date rec'd by registrar) FRANK J. TOLLISON, CAPT., MC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 0802 - 15 February 1946 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 14 Feb 1946 to 15 Feb 1946 and that I last saw him alive on 15 Feb 1946

Immediate cause of death	DURATION
Shock, hemorrhage	
secondary to multiple avulsion	
wounds of left arm and left leg.	
Due to compound fracture of skull	
following explosion.	17 hrs.
Due to High explosive detonation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Multiple avulsion wounds left arm and leg, compound fracture skull. Date of op. 14 Feb 1946
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 14 Feb 1946
Where did injury occur? FORT George G Meade (City or town) Md. (County) (State)
Injured at home, farm, industry, public place (where?) on duty
Means of injury: Accidental detonation of explosive Injured at work? duty

23. SIGNATURE: John de Remarett, 1st Lt, MC M. D. or other
Address: Regional Hospital, Ft G Meade, Md Date signed: 15 Feb 46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02072

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:

County Anne Arundel Co

City or town Bacons near Laurel (Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Anne Arundle

City or town Laurel R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Earl Stewart Williams

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct 23 1945

8. AGE: Years	Months	Days	If less than one day
	3	8	..... hrs. ..... min.

9. Birthplace Anne Arundle Co near Laurel Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Lawson Garnet

13. Birthplace Virginia

MOTHER 14. Maiden name Vez Williams

15. Birthplace Maryland

16. Informant Mrs. Williams

Address Bacons near Laurel Md

17. Burial Date thereof Feb 3 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Bacons Cemetery

Location near Laurel Md

18. Funeral director Ridgely Selby

Address 101 Main St Laurel Md

19. Feby 2 1946 Mace Hartley

(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb - 1 1946 at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/29 1946 to 2/1 1946 and that I last saw him alive on 1/30 1946

Immediate cause of death	DURATION
Bronco Pneumonia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D B Summers M. D. or other

Address Laurel Md Date signed 2/3/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING